SUMMARY #3

SUMMARY COMMENTS FROM AUGUST 22, 2011 STAKEHOLDER MEETING

REGARDING THE TRANSFER OF THE DRUG MEDI-CAL PROGRAM TO DHCS

- There was discussion regarding how the transitioned Drug Medi-Cal Treatment Program (DMC) will interface with the new Low Income Health Program, the Seriously Disabled Persons program, and other new Medi-Cal programs under the Bridge to Reform waiver or federal health care reform (HCR) in general.
- DMC should link with these new programs (above), but it is still important to retain the integrity and focus on those service needs unique to the alcohol and drug field.
- Many alcohol and drug services are not provided in medical/clinical settings and this service field has special competencies. A move toward integration overlooks the fact that some services are highly specialized and cannot be delivered by a primary care provider
- Coordination and/or integration of DMC with other health care services could be advantageous for beneficiaries with dual diagnoses.
- DHCS was asked if there is still a plan to integrate behavioral health. Concern was voiced that the establishment of two divisions/offices means DHCS is backtracking on consolidation.
- Integration is a discussion for today and there should be a work group on this now.
- There has been stakeholder objection to the term “behavioral health” - the draft plan made no reference to this stakeholder concern – is DHCS open to other names? Consider the federal Substance Abuse and Mental Health Services Administration approach.
- DHCS should clarify the term “behavioral health” in the transition plan.
- “Behavioral Health” may not be the best term for the new DHCS Division. This term may have too strong of an association with the criminal justice system.
- Some stakeholders had questions and concerns regarding the State’s inter-departmental (Department of Alcohol and Drug Programs (DADP) and Department of Health Care Services (DHCS)) “workgroup” process. There were some questions whether stakeholders should be included in the DADP/DHCS “workgroups” and a request was made to release the workgroup member contact information. Future transition updates should include the workgroup recommendations. [editor’s note: The current workgroups are focusing on administrative tasks associated with the transfer, not administrative or programmatic policy change.]
- A specific “integration” workgroup could be established to deal with transition, realignment and federal HCR. Stakeholders would like to participate in State “workgroups” where integration or other major program changes are to be considered.
- Realignment as well as federal HCR will create questions for county DMC programs whether they should consider going from a fee-for-service (FFS) to a managed care model. Implementation of “quality outcome” measures may depend on more of a managed health care approach.
- The draft transition plan needs to address realignment

- A request was made to clarify whether the State could/would continue to contract with non-county direct providers in light of realignment (AB 118). AB 118 language needs clean up.
- The transition plan does not clarify if DHCS will take on the DMC provider certification role.
- The State should accept the national certification of alcohol and drug providers and not require an additional Medi-Cal certification for Drug Medi-Cal program participation.
- For specialty services such as alcohol and drug treatment – primary care should do the screening and assessment and have strong referral protocols for specialty alcohol and drug program services.
- Mental health clients have a key interest in what happens to DMC; many of them are dually diagnosed.
- The managed care language regarding quality management and quality assurance on page 12, first full paragraph, is negative and implies providers do not care about quality.
- Page 20, 1st paragraph under “Reporting”: support, analyze or strike the statement regarding NTP being the most costly.
- The draft plan references a separate non-Medi-Cal stakeholder process for DADP; the stakeholder is not aware this is occurring.
- State regulations prevent use of best practices; things are allowed in statute but not state regulations or the State Plan; Naltrexone is once per day but there is now an injection that is effective for 30 days; despite past assertions, there is no proof that the state regulations result in a more effective program
- DADP should accept national certification in lieu of state alcohol and other drug certification; this is the real concern of providers not DMC certification.
- Add Vivitrol to the DMC benefit.
- The State needs to consider how to effectively coordinate the transition of the Short-Doyle Medi-Cal Phase II electronic claims processing system, other billing support systems, and cost settlement/ audit functions for both DMC and specialty mental health services if the State is going to achieve cost savings in the transition.
- This transfer does not appear to be a cost savings; stakeholder has spoken with DHCS Information Technology staff and know that the two departments’ systems do not talk to each other; this will eventually result in huge costs. Will this process halt when the government realizes this is creating a cost, not a savings?